DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 0 0 — 0 1 4

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 USC 1396r-4
42 USC 1396a(a)(13); 42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 14,300*
b. FFY 2002 $ 14,300*

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19 A(1)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Acute Hospital Payment Methods

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not required under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Wendy E. Warring by Phyllis Bates

13. TYPED NAME: Wendy E. Warring

14. TITLE: Commissioner

15. DATE SUBMITTED: December 29, 2000

16. RETURN TO:
Bridget Landers
Coordinator for State Plan
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: December 29, 2000

18. DATE APPROVED: August 23, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: December 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:
Dennis M. Maloney for

21. TYPED NAME: Ronald P. Preston

22. TITLE: Associate Regional Administrator, DMSO

23. REMARKS:

# OFFICIAL

FORM HCFA-179 (07-92) *Instructions on Back*

* in thousands

**Methods Used to Determine Rates of Payment for Acute Inpatient Hospital Services**

## I: OVERVIEW

On September 28, 2000, the Division of Medical Assistance of the Executive Office of Health and Human Services (hereafter referred to as "the Division") issued a Request for Application (RFA) to solicit applications from eligible, in-state Acute Hospitals which seek to participate as MassHealth providers of Acute Hospital services. The goal of the RFA was to enter into contracts with all eligible Acute Hospitals in Massachusetts which accept the method of reimbursement set forth below as payment in full for providing MassHealth Members with the same level of clinical services as is currently provided by those Hospitals and their Hospital-Licensed Health Centers. In-state Acute Hospitals which: (1) operate under a Hospital license issued by the Massachusetts Department of Public Health (DPH); (2) participate in the Medicare program; (3) have more than fifty percent (50%) of their beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or II), pediatric intensive care (Level III), maternal (obstetrics) or neonatal intensive care beds (Level III), as determined by DPH; and (4) currently utilize more than fifty percent (50%) of their beds as such, as determined by the Division, are eligible to apply for a contract pursuant to the RFA.

The RFA, as amended November 16, 2000, is effective December 1, 2000 with the following data source and inflation updates. Other methodological changes are contained within.

- Operating and capital cost data was taken from the Division of Health Care Finance and Policy (DHCFP) 403 cost reports submitted for 1998;
- An inflation adjustment of 2.0% was applied to operating costs and the administrative day rates. Due to the start date of December 1, 2000, such inflation was adjusted to 2.4%;
- An inflation adjustment for capital costs of 0.9% was applied. Due to the start date of December 1, 2000, such inflation was adjusted to 1.08%;
- The inpatient casemix adjustment was updated to reflect audited paid claims from the period of 6/1/99-5/31/00;
- The wage area adjustment was updated to reflect the most recent HCFA wage index information;
- Pass-through and direct medical education amounts were rebased to 1999.

## II: DEFINITIONS

**Administrative Day (AD)** - A day of inpatient hospitalization on which a Member's care needs can be provided in a setting other than an Acute Hospital, and on which the Member is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available. See 130 • CMR 415.415 and 415.416 attached as Exhibit 1.

**Administrative Day Per Diem** - An all-inclusive per diem payable to Hospitals for administrative days.

**Behavioral Health Program (BHP)** – A managed care program for the provision of mental health and substance abuse services to MassHealth Members enrolled in the program.

**Behavioral Health (BH) Contractor** – The entity with which the Division contracts to administer the Division's Behavioral Health Program.

**Clinical Laboratory Service** - Microbiological, serological, chemical, hematological, biophysical, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

**Community-Based Entity** – Any entity that is not a Hospital-Based Entity.

**Community-Based Physician** - Any physician, excluding interns, residents, fellows and house officers, who is not a Hospital-Based Physician. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths.

**Contract (Hospital Contract or Agreement)** - The agreement executed between each selected Hospital and the Division, which incorporates all of the provisions of the RFA.

**Contractor** - Each Hospital that is selected by the Division after submitting a satisfactory application in response to the RFA and that enters into a contract with the Division to meet the purposes specified in the RFA.

**Distinct Part Psychiatric Unit (DPU)** - An Acute Hospital's psychiatric unit that meets all requirements of 42 C.F.R. Part 412.

**Division** - The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Division of Medical Assistance.

**Division of Health Care Finance and Policy (DHCFP)** - a Division of the Commonwealth of Massachusetts, Executive Office of Health and Human Services created pursuant to G.L. c.118G. DHCHP performs many of the functions performed by the former Rate Setting Commission and former Division of Medical Security.

**Early Maternity Discharge** – A discharge from inpatient care less than 48 hours after a vaginal delivery and less than 96 hours after a caesarian delivery.

**Excluded Units** – Non-Acute Units as defined in this section; Psychiatric and Substance Abuse units; and Non-distinct Observation Units.

**Gross Patient Service Revenue** - The total dollar amount of a Hospital's charges for services rendered in a fiscal year.

**Hospital (also referred to as Acute Hospital)** - Any Hospital licensed under M.G.L. c. 111, §51, and which meets the eligibility criteria set forth in **Section I**.

**Hospital-Based Entity** - Any entity that contracts with a Hospital to provide medical services to Members on the same site as the Hospital's inpatient facility.

**Hospital-Based Physician** - Any physician, excluding interns, residents, fellows, and house officers, who contracts with a Hospital or Hospital-Based Entity to provide services to Members, on the same site as the Hospital's inpatient facility. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives and physician assistants are not Hospital-Based Physicians.

**Hospital-Specific Standard Payment Amount per Discharge (SPAD)** - An all-inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which is complete reimbursement for an acute episode of illness, excluding the additional payment of Outliers, Transfer per Diems, and Administratively Necessary Days.

**Inpatient Admission** – The admission of a Member to an Acute Hospital for the purposes of receiving inpatient services in that Hospital.

**Inpatient Services** - Medical services provided to a Member admitted to an Acute Hospital. 130 CMR 415.414, the regulations referenced therein, Appendix F to the Division's Acute Inpatient Hospital Manual, the Division's billing instructions, and the RFA contain payment rules regarding Inpatient Services. See Exhibit 2.

**Managed Care Organization (MCO)** - Any entity with which the Division contracts to provide primary care and certain other medical services to members on a capitated basis, including an entity that is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO) or that otherwise meets the state plan definition of an HMO.

**MassHealth (also referred to as Medicaid)** - The Medical Assistance Program administered by the Division to furnish and pay for medical services pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act, and any approved waivers of such provisions.

**Member (also referred to as recipient)** - A person determined by the Division to be eligible for medical assistance under the MassHealth program.

**Non-Acute Unit** – A Chronic Care, Rehabilitation or Skilled Nursing Facility within a Hospital.

**Outlier Day** - Each day during which a Member remains Hospitalized at acute (non-psychiatric) status beyond twenty acute days during the same, single admission. AD days occurring within the period of Hospitalization are not counted toward the outlier threshold as described in **Section IV.B.11**.

**Pass-Through Costs** - Organ acquisition, malpractice, and direct medical education costs that are paid on a cost-reimbursement basis and are added to the Hospital-specific standard payment amount per discharge.

**Pediatric Specialty Hospital** - An Acute Hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

**Pediatric Specialty Unit** - A pediatric unit in an Acute Hospital in which the ratio of licensed pediatric beds to total licensed Hospital beds as of July 1, 1994 exceeded 0.20, unless located in a facility already designated as a Specialty Hospital.

**Primary Care Clinician Plan (PCC Plan)** - A comprehensive managed care plan, administered by the Division, through which enrolled Members receive Primary Care and certain other medical services.

**Public Service Hospital** - Any public Acute Hospital or any Acute Hospital operating pursuant to Chapter 147 of the Acts & Resolves of 1995 (see attached Exhibit 3) which has a private sector payer mix that constitutes less than twenty five percent (25%) of its gross patient service revenue (GPSR) and where uncompensated care comprises more than twenty percent (20%) of its GPSR.

**Rate Year (RY)** – Generally, the period beginning October 1 and ending September 30; provided, however, that RY00 began October 1, 1999 and was extended through November 30, 2000. RY01 begins on December 1, 2000 and ends on September 30, 2001.

**Sole Community Hospital** - Any Acute Hospital classified as a sole community Hospital by the U.S. Health Care Financing Administration's Medicare regulations, or any Hospital which demonstrates to the Division of Health Care Finance and Policy's satisfaction, that it is located more than 25 miles from other Acute Hospitals in the Commonwealth and which provides services for at least sixty percent (60%) of their primary service area.

**Specialty Hospital** - Any Acute Hospital which limits admissions to children or to patients under active diagnosis and treatment of eyes, ears, nose, and throat, or diagnosis and treatment of cancer, and which qualifies as exempt from the Medicare prospective payment system regulations.

**Transfer Patient** - Any patient who meets any of the following criteria: 1) transferred between Acute Hospitals; 2) transferred between a Distinct Part Psychiatric Unit and a medical/surgical unit in an Acute Hospital; 3) receiving substance abuse or psychiatric-related services whose assignment in the BHP changes; 4) who becomes eligible for MassHealth after the date of admission and prior to the date of discharge; or 5) is a Member who exhausts other insurance benefits after the date of admission and prior to the date of discharge.

**Upper Limit** - The term referring to the level below which it is determined that the Hospital reimbursement methodology will result in payments for Hospital services in the aggregate that are no more than the amount established by federal law.

**Usual and Customary Charges** - Routine fees that Hospitals charge for Acute Hospital services rendered to patients regardless of payer source.

## III. NON-COVERED SERVICES

The Division will reimburse MassHealth participating Hospitals at the rates established in the RFA and accompanying contract for all Acute Services provided to MassHealth Members except for the following:

### A. Behavioral Health Services for Members Assigned to the BHP

The Division's BH Contractor contracts with a provider network to deliver psychiatric and substance abuse services for MassHealth Members enrolled in the BHP. Hospitals in the BHP network are paid by the BH Contractor for services to Members assigned to the BHP, pursuant to contracts between the BH Contractor and each contracting Hospital.

Hospitals that are not in the BH Contractor's network (hereinafter "Non-Network Hospitals") do not qualify for Medicaid reimbursement for BHP Members seeking psychiatric or substance abuse non-Emergency Services, except in accordance with a service specific agreement with the BH Contractor.

Non-Network Hospitals that provide medically necessary psychiatric and substance abuse Emergency Services to BHP Members qualify for reimbursement solely by the BH Contractor.

Hospitals are not entitled to any reimbursement from the Division, and may not claim such reimbursement for any services that are BHP-covered services or are otherwise reimbursable by the BH Contractor.

### B. MCO Services

Hospitals providing services to MassHealth Members enrolled in MCOs will be reimbursed by the MCO for those services.

Hospitals may not bill the Division, and the Division will not reimburse Hospitals for services provided to MassHealth Members enrolled in an MCO where such services are covered by the MCO's contract with the Division. Furthermore, Hospitals may not "balance bill" the Division for any services covered by the MCO's contract with the Division. MCO reimbursement shall be considered payment in full for any MCO-covered services provided to MassHealth Members enrolled in an MCO.

### C. Air Ambulance Services

In order to receive reimbursement for air ambulance services, providers must have a separate contract with the Division for such services.

**D. Hospital Services Reimbursed through Other Contracts or Regulations**

The Commonwealth may institute special program initiatives other than those listed above which provide, through contract and/or regulation, alternative reimbursement methodologies for Hospital services or certain Hospital services. In such cases, payment for such services is made pursuant to the contract and/or regulations governing the special program initiative, and not through the RFA and resulting Contract.

**E. Non-Acute Units in Acute Hospitals**

Except as otherwise provided in **Section IV.B.13**, the Division shall not reimburse Acute Hospitals through the RFA for services provided to Members in Non-Acute Units within Acute Hospitals.

## IV: REIMBURSEMENT SYSTEM

### A. Data Sources

In the development of each Hospital's standard payment amount per discharge (SPAD), the Division used June 1, 1999 through May 31, 2000 MassHealth audited paid SPAD claims; the FY98 DHCFP 403 report, submitted by each Hospital to DHCFP; and the RY98 Merged Casemix/Billing Tapes as accepted by DHCFP, as the primary sources of data to develop base operating costs. The wage area adjustment was derived from the HCFA Hospital Wage Index Public Use File (FY97 Final, updated as of May 12, 2000).

### B. Methodology for Inpatient Services

#### 1. Overview

Payments for inpatient services provided to MassHealth members not enrolled in an MCO, other than for psychiatric services provided in Distinct Part Psychiatric Units, will consist of the sum of 1) a statewide average payment amount per discharge that is adjusted for wage area differences and the Hospital-specific MassHealth casemix; 2) a per discharge, Hospital-specific payment amount for Hospital-specific expenses for malpractice and organ acquisition costs; 3) a per discharge, Hospital-specific payment amount for direct medical education costs which includes a Primary Care training incentive and a specialty care reduction; and 4) a per discharge payment amount for the capital cost allowance, adjusted by Hospital-specific casemix. Each of these elements is described in **Sections IV.B.2 through IV.B.6**.

Payment for psychiatric services provided in Distinct Part Psychiatric Units to MassHealth patients who are not served either through a contract between the Division and its BH contractor or an MCO shall be made through an all-inclusive regional weighted average per diem updated for inflation.

Payment for physician services rendered by Hospital-Based Physicians will be made as described in **Section IV.B.10**.

#### 2. Calculation of the Standard Payment Amount Per Discharge (SPAD)

The statewide average payment amount per discharge is based on the actual statewide costs of providing Inpatient Services in FY98. The statewide average payment amount per discharge for RY01 was determined using the FY98 DHCFP Merged Billing and Discharge Data and the FY98 DHCFP 403 as screened and updated as of September 15, 2000. Cost

and utilization data for Excluded Units were omitted from calculation of the statewide average payment amount per discharge.

The average payment amount per discharge in each Hospital was derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges, omitting those costs and discharges from Excluded Units. Routine outpatient costs associated with admissions from ED and observation beds were included. The cost centers that are identified as the supervision component of physician compensation and other direct physician costs were included; professional services were excluded. All other medical and non-medical patient care-related staff expenses were included.

Malpractice costs, organ acquisition costs, capital costs and direct medical education costs were excluded from the calculation of the statewide average payment amount per discharge.

The average cost per discharge for each Hospital was then divided by the Hospital's Massachusetts-specific wage area index and by the Hospital-specific FY98 all-payer casemix index using the Version 12.0 New York Grouper and New York weights. For the non-exempt Massachusetts Hospitals in the areas designated by the Geographical Classification Review Board of the Health Care Financing Administration, effective September 1, 1995, the average hourly wage of each area was calculated from the HCFA Hospital Wage Index Public Use File (FY97 Final, updated as of May 12, 2000). Each area's average hourly wage was then divided by the statewide average hourly wage to determine the area's wage index. For the calculation of the Springfield area index, BayState Medical Center's wages and hours were included. This step results in the calculation of the standardized costs per discharge for each Hospital.

The Hospitals were then ranked from lowest to highest with respect to their standardized costs per discharge; a cumulative frequency of MassHealth discharges for the Hospitals was produced. The RY01 efficiency standard was established at the cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 75 percent of the total number of statewide discharges. The RY01 efficiency standard is $3,298.26.

The RY01 statewide average payment amount per discharge was then determined by multiplying a) the weighted mean of the standardized cost per discharge, as limited by the efficiency standard; by b) the outlier adjustment factor of ninety-five percent (95%); and by c) an inflation factor of 1.9% which reflects price changes between RY98 and RY99; by d) an inflation factor of 1.43% which reflects price changes between RY99 and RY00; and by e) an inflation factor of 2.00% which reflects price changes between RY00 and RY01. Each inflation factor is a blend of the HCFA market basket and the Massachusetts

Consumer Price Index (CPI). Specifically, the CPI replaces the labor-related component of the HCFA market basket to reflect conditions in the Massachusetts economy. Due to the start date of December 1, 2000, inflation between RY00 and RY01 will be adjusted to 2.4% for claims with admission dates of December 1, 2000 through September 30, 2001. The resulting statewide average payment amount per discharge is $2,815.34.

The RY01 statewide average payment amount per discharge was then multiplied by the Hospital's MassHealth casemix index adjusted for outlier acuity index (using version 12.0 of the New York Grouper and New York weights) and the Hospital's Massachusetts specific wage area index to derive the Hospital-specific standard payment amount per discharge (SPAD). The wage area indices were derived from the HCFA Hospital Wage Index Public Use File (FY97 Final, updated as of May 12, 2000).

The outlier adjustment is used for the payment of Outlier Days as described in **Section IV.B.9.**

Efficient low-cost Hospitals will receive an add-on to their SPAD as set forth in **Section IV.B.14.**

When groupers are changed and modernized, it is necessary to adjust the base payment rate so that overall payment levels are not affected solely by the grouper change. This aspect of "budget neutrality" is an approach that the Division is following, and one that has been a feature of the Medicare DRG program since its inception. The Division reserves the right to update to a new grouper.

3. **Calculation of the Pass-through Amount per Discharge**

The inpatient portion of malpractice and organ acquisition costs was derived from each Hospital's FY99 DHCFP 403 report as screened and updated as of September 8, 2000. The pass-through amount per discharge is the sum of the Hospital's per discharge costs of malpractice and organ acquisition. In each case, the amount is calculated by dividing the Hospital's inpatient portion of expenses by the number of total, all-payer days and then multiplying the cost per diem by the Hospital-specific MassHealth (non-psychiatric/substance abuse) average length of stay from casemix data. The Division used the MassHealth audited Hospital-specific paid SPAD claims file for date of payment for the period June 1, 1999 through May 31, 2000 to develop the Hospital's RY01 casemix index.

The RY01 pass-through amount per discharge is the product of the per diem costs of inpatient malpractice and organ acquisition and the Hospital-specific MassHealth average length of stay from casemix data, omitting such costs related to services in Excluded Units.

The days used in the denominator are also net of days associated with such units.

4. **Direct Medical Education**

The inpatient portion of direct medical education costs was derived from each Hospital's FY99 DHCFP 403 report as screened and updated as of September 8, 2000. The amount was calculated by dividing the Hospital's inpatient portion of direct medical education expenses by the number of total inpatient days and then multiplying the cost per diem by the Hospital-specific MassHealth (non-psychiatric/substance abuse) average length of stay from the casemix data referenced in this section above. The Division has incorporated an incentive in favor of Primary Care training which was factored into the recognized direct medical education costs by weighting costs in favor of Primary Care resident training. An incentive of 33% of each Hospital's costs was added to its per discharge cost of Primary Care resident training; 20% of each Hospital's costs was subtracted from its per discharge costs of specialty care resident training, provided, however, that the 20% reduction was not applied to the costs of specialty care resident training at Pediatric Specialty Hospitals and Hospitals with Pediatric Specialty Units. The number of Primary Care and specialty care residents was derived from data provided to the Division by the Hospitals.

5. **Capital Payment Amount per Discharge**

The RY01 capital payment per discharge is a standard, prospective payment for all Hospitals except for those Hospitals with unique circumstances as set forth in **Section IV.D**, which meet the criterion set forth in the final paragraph of this section. The capital payment is a casemix-adjusted capital cost limit, based on the FY98 DHCFP 403 Cost Report, updated for inflation.

For each Hospital, the total inpatient capital costs include building and fixed equipment depreciation, major moveable equipment depreciation, major moveable equipment, and long- and short-term interest. Total capital costs are allocated to Inpatient Services through the square-footage-based allocation formula of the DHCFP 403 Cost Report. Capital costs for Excluded Units were omitted to derive net inpatient capital costs. The capital cost per discharge for RY01 was calculated by dividing total net inpatient capital costs by the Hospital's total FY98 days, net of Excluded Units' days, and then multiplying by the Hospital-specific acute MassHealth average length of stay from casemix data from the period June 1, 1999 to May 31, 2000.

The RY01 casemix-adjusted capital efficiency standard was determined by a) dividing each

Hospital's FY98 capital cost per discharge by its FY98 MassHealth casemix index; b) sorting these adjusted costs in ascending order; and c) producing a cumulative frequency of discharges. The casemix-adjusted efficiency standard was established at the capital cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 75 percent of the total number of statewide discharges.

Each Hospital's capital cost per discharge was then held to the lower of their capital cost per discharge or the casemix-adjusted efficiency standard, to arrive at a capped capital cost per discharge. Each Hospital's capped capital cost per discharge is then multiplied by the Hospital's number of MassHealth discharges. The product of the capped capital cost per discharge and the number of MassHealth discharges for each Hospital was then summed and divided by the total number of MassHealth discharges statewide, to arrive at a statewide weighted average capital cost per discharge.

The statewide weighted average capital cost per discharge was then updated for inflation between RY98 and RY99 by a factor of 0.80%; between RY99 and RY00 by a factor of 0.00% (no inflation adjustment); and between RY00 and RY01 by a factor of 0.90%. Due to the start date of December 1, 2000, capital inflation will be adjusted to 1.08% for claims with dates of admission of December 1, 2000 through September 30, 2001. The capital update factor was taken from annual HCFA regulations, and is the factor used by HCFA to update the capital payments made by Medicare. The statewide weighted average capital cost per discharge for RY01 is $344.56.

The Hospital-specific capital payment per discharge was determined by multiplying the statewide weighted average capital cost per discharge of $344.56 by the Hospital's RY01 casemix index as determined in **Section IV.B.5** above.

If a Hospital's RY00 capital payment per discharge is greater than its RY01 capital payment per discharge as calculated above and adjusted for inflation and case mix, and the Hospital otherwise qualifies for reimbursement pursuant to **Section IV.D**, the Hospital's RY01 capital payment will equal the Hospital's incurred capital costs, capped at twice the statewide weighted average capital cost per discharge.

6. **Maternity and Newborn Rates**

Maternity cases in which delivery occurs will continue to be paid on a SPAD basis with one SPAD paid for the mother and one SPAD paid for the newborn. Payment for *all* services (except physician services) provided in connection with such a maternity stay including, but not limited to, one follow-up home visit provided in connection with Early Maternity Discharge, are included in the SPAD amount.

The Division will make no additional payments to the Hospital or other entities (i.e., VNAs, home health agencies) for providing the services described in this section. Hospitals are required to apply any and all maternity and newborn policies and programs equally to all patients, regardless of payer.

7. **Payment for Psychiatric Services in Distinct Part Psychiatric Units**

Services provided to MassHealth patients in Distinct Part Psychiatric Units who are not enrolled with the BH Contractor or an MCO shall be paid through an all-inclusive regional weighted average per diem. This payment mechanism does not apply to cases in which psychiatric or substance abuse services are provided to MassHealth Members assigned to the BHP or an MCO, except as set forth in **Section III.A and B**.

The regions used to develop the all-inclusive regional weighted average per diem rates correspond to the six Health Services Areas established by the Massachusetts Department of Public Health (PL 93-641). These regional weighted average per diems were calculated by a) dividing each Hospital's per discharge psychiatric rate established in the RY92 MassHealth RFA by the FY90 average length of stay pertaining to MassHealth psychiatric patients; b) multiplying the result for each Hospital by the ratio of the Hospital's MassHealth psychiatric days to the total MassHealth psychiatric days for the Hospital's region; and c) summing the results for each region. The regional weighted average per diems were updated using inflation factors of 3.35% to reflect price changes between RY92 and RY93; 3.01% to reflect price changes between RY93 and RY94; 2.80% to reflect price changes between RY94 and RY95; 3.16% to reflect price changes between RY95 and RY96; 2.38% to reflect price changes between RY96 and RY97; 2.14% to reflect price changes between RY97 and RY98; 1.90% to reflect price changes between RY98 and RY99; 1.43% to reflect price changes between RY99 and RY00; and 2.0% to reflect price changes between RY00 and RY01. Due to the start date of December 1, 2000, inflation between RY00 and RY01 will be adjusted to 2.4% for claims with dates of admission of December 1, 2000 through September 30, 2001.

8. **Transfer Per Diem Payments**

a. **Transfer Between Hospitals**

In general, payments for patients transferred from one Acute Hospital to another will be made on a transfer per diem basis capped at the SPAD for the Hospital that is transferring the patient.

In general, the Hospital that is receiving the patient will be paid on a per discharge basis in accordance with the standard methodology specified in **Sections IV.B.2** through **5**, if the patient is discharged from that Hospital. If the patient is transferred to another Hospital, then the transferring Hospital will be paid at the Hospital-specific transfer per diem rate, capped at the Hospital-specific per discharge amount. Additionally, "back transferring" Hospitals will be eligible for outlier payments specified in **Section IV.B.9** below.

Except as otherwise provided in the following paragraph, the RY01 payment per day for Transfer Patients shall equal the statewide average payment amount per discharge divided by the FY98 average all-payer length of stay of 4.5035 days, to which is added the Hospital-specific capital, direct medical education and pass-through per diem payments which are derived by dividing the per discharge amount for each of these components by the Hospital's MassHealth average length of stay from casemix data. This amount is multiplied by 1.03 to account for casemix complexity of transfer cases, and then by 1.25 to arrive at an enhanced transfer per diem.

For Hospitals with unique circumstances reimbursed in accordance with the methodology specified in **Sections IV.D.1** through **3**, the RY01 payment amount per day for transfer patients shall equal the individual Hospital's standard inpatient payment amount per discharge divided by the individual Hospital's FY98 all-payer length of stay, to which is added the Hospital-specific capital, direct medical education and pass-through per diem payments which are derived by dividing the per discharge amount for each of these components by the Hospital's MassHealth average length of stay from casemix data. This amount is multiplied by 1.03 to account for casemix complexity of transfer cases.

Refer to matrices attached in Exhibit 4 for a review of transfer scenarios and corresponding payment mechanisms involving BHP-eligible and BHP-ineligible Members in BH Contractor's network and non-network Hospitals.

**b. Transfers within a Hospital**

In general, a transfer within a Hospital is not considered a discharge. Consequently, in most cases a transfer between units within a Hospital will be reimbursed on a per diem basis. This section outlines reimbursement under some specific transfer circumstances. For a comprehensive review of reimbursement under transferring circumstances involving BHP-eligible Members and BHP-ineligible Members in the BH network and non-network Hospitals, refer to the

matrices attached in Exhibit 4.

(1) Transfer to/from a Non-Acute Unit within the Same Hospital

If a patient is transferred from an acute bed to a Non-Acute unit in the same Hospital, the transfer is considered a discharge. The Division will pay the Hospital-specific SPAD for the portion of the stay before the patient is transferred to a Non-Acute Unit.

(2) MassHealth Payments for Newly Eligible Members or in the Event of Exhaustion of Other Insurance

When a patient becomes MassHealth-eligible or other insurance benefits have been exhausted after the date of admission and prior to the date of discharge, the acute stay will be paid at the transfer per diem rate, up to the Hospital-specific SPAD, or, if the patient is at the Administrative Day level of care, at the AD per diem rate.

(3) Admissions Involving One-Day Length of Stay Following Outpatient Surgical Services

If a patient who requires Hospital inpatient services is admitted for a one-day stay following outpatient surgery, the Hospital shall be paid at the transfer per diem rate instead of the Hospital-specific SPAD.

(4) Transfer between a Distinct Part Psychiatric Unit and Any Other Bed within the Same Hospital

Reimbursement for a transfer between a Distinct Part Psychiatric Unit and any other bed within a Hospital will vary depending on the circumstances involved, such as managed care status, BH Network or Non-Network Hospital, or the type of service provided. Please refer to the appropriate matrix in Exhibit 4 for reimbursement under specific transfer circumstances involving psychiatric and substance abuse stays.

(5) Change of Managed Care Status during a Psychiatric or Substance Abuse Hospitalization

(a) Payments to Hospitals *without* network provider agreements with the Division's BH Contractor

When a Member enrolls in the BHP during a non-emergency or emergency psychiatric or substance abuse admission at a non-network Hospital, the portion of the Hospital stay during which the Member is enrolled in the BHP shall be paid by the Division's BH Contractor provided that the Hospital complies with the BH Contractor's service authorization and billing policies and procedures. The portion of the Hospital stay during which the Member was not enrolled in the BHP will be paid by the Division at the psychiatric per diem rate for psychiatric services or at the transfer per diem rate for substance abuse services, capped at the Hospital-specific SPAD.

(b) Payments to Hospitals *with* network provider agreements with the Division's BH contractor

When a member enrolls in the BHP during an emergency or non-emergency psychiatric or substance abuse Hospital admission, the portion of the Hospital stay during which the Member is enrolled in the BHP shall be paid by the Division's BH Contractor provided that the Hospital complies with the BH Contractor's service authorization and billing policies and procedures. The portion of the Hospital stay during which the Member was not enrolled in the BHP will be paid by the Division at the psychiatric per diem for psychiatric services or at the transfer per diem rate for substance abuse services, capped at the Hospital-specific SPAD.

**9. Outlier Payments**

**a. Eligibility**

A Hospital qualifies for an outlier per diem payment in addition to the Hospital-specific standard payment amount per discharge if ***all*** of the following conditions are met: